that the renal pelvis was accurately occupied by the drainage catheter was to slit the ureter near the pelvis for insertion of delicate curved forceps which was then pushed through pelvis or central calyx and on through parenchyma and cortex here to grasp the catheter and draw it back into the pelvis. Removing forceps to suture the ureteral slit. The kidneys in these nephrostomy cases are apt to have normal pelves, small, collapsed envelope-like spaces, gaining an instrumental entrance to which from the surface of the kidney is fraught with uncertainty. The instrument is as apt to bring up at the hilum *outside* the pelvis walls, as *between* these two closely opposed surfaces. The finger, of course, might be a reliable guide, but kidney puncture by so large an object is unnecessarily damaging.

TUBERCULOSIS OF THE TESTIS.

Dr. F. Tilden Brown presented a man, 34 years old, a machinist by occupation. His immediate family history was good, but four of his uncles had died of pulmonary tuberculosis. He had formerly used alcohol to excess. When he was nine years old he had an attack of hematuria lasting one day, for which no cause could be assigned. About that time he was said to have had repeated attacks of malaria. When he was thirteen years old he began to lose flesh, and developed a cough, with bloody expectoration. He was sent to the country for four months, where he gained decidedly in weight and strength.

Ten years ago the left testicle became swollen, red and painful. Within a month it broke down and discharged, the sinus healing in three months without any treatment. The testis, however, still remained swollen and tender, and three months later it broke down again. At that time the patient was having frequent nightsweats; he felt weak and was losing weight. The testis was curetted with good result.

On August 15, 1907, "after a heavy lift," the right testis became swollen, but not painful. It was five inches in length and three and a half inches in diameter. It subsequently broke down and discharged, leaving a circular ulcer. The patient still had nightsweats at irregular intervals. He was admitted to Bellevue Hospital on October 8, 1907. His temperature at that time varied but little from the normal. The main interest then was a differential diagnosis between gummatous, cancerous, tuberculous ulcer

and ulcer due to chronic localized urinous infiltration. While the history and state of the contained organs was almost enough in itself to justify the diagnosis of tuberculous ulcer of the scrotum secondary to that of the epididymis and testis, the appearance, unusual size and hard induration of the margins was much more suggestive of epithelioma. As had been his experience in the majority of such cases, tubercle bacilli were readily found in the discharge.

Operation.—A complete removal of all the tissue involved, guarding against any chance of soiling the new surface, was aimed at. The testis was pretty completely infiltrated, but with a later development of tuberculosis than that in the epididymis. The vas was not involved at the point of severing the cord.

FURTHER OBSERVATIONS ON THE TREATMENT OF PARALYTIC TALIPES CALCANEUS BY ASTRAGALECTOMY AND BACKWARD DISPLACEMENT OF THE FOOT.

Dr. Royal Whitman read a paper with the above title for which see page 264.

In connection with his paper, Dr. Whitman presented a number of patients upon whom he had performed this operation.

Dr. F. Tilden Brown said that the theory upon which Dr. Whitman had based his operation appeared to him as wise. The speaker said that some years ago he was impressed with the comparatively insignificant functional importance of the astragalus by the case of a young man who was thrown from his horse, receiving a severe injury of the lower leg, including a Pott's fracture and a dislocation of the astragalus. Dr. McBurney urged removal of the bone. This resulted in scarcely noticeable shortening. The patient made an excellent functional recovery, and in comparatively short time was able to play tennis, ride, and dance about as well as before.

Dr. Woolsey said the cases demonstrated by Dr. Whitman were certainly excellent, especially when we had in mind the severe type of deformity from which these patients had suffered. It was remarkable with what impunity the astragalus could be handled. The speaker said he had removed the bone several times to correct the deformity resulting from equinovarus, but he had never done the operation in talipes calcaneus.